Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS640HOS	A. BUILDING _____ B. WING _____	05/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 05/21/10 and finalized on 05/24/10, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00025388 was substantiated with deficiencies cited. (See Tags S0300, S0310, S0150, S0154) A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified.	S 000	Introduction Immediately following the event the following actions were implemented to protect the safety of MountainView patients at risk for self harm. On May 20, 2010 a Mental Health Task Force was formed comprised of ED and Med/Surg Nursing Directors, Case Management Director, Nurse Educator, VP Quality, Patient Safety Officer, and CNO. On June 1, 2010, the Task Force retained a Mental Health Consultant who met with the membership, toured the facility, assessed documents, and provided education. The Task Force created two subcommittees, one for discharge planning and one for care of the patient to develop, review and revise more robust processes for screening and monitoring at risk patients. Beginning on May 20, 2010, in the ED, RN staff including RNs, LPNs, CNAs, Sitters, EMS greeters and Unit Coordinators were reeducated regarding sitter responsibilities, toileting procedures, bathroom safety procedures and the need to notify the Charge RN for any observed changes in behavior while serving in the sitter capacity. (Attachment I) The Suicide Risk Assessment Policy (Attachment 2) was reviewed with all ED RN staff presenting for their shift beginning on May 20, reinforcing that anyone presenting with unusual behaviors, signs and symptoms of psychiatric, behavioral, drug or alcoholism or with a history of same or those with a history of use of psychiatric medications will get a suicide risk assessment. If additional information comes to light after the initial assessment that places the patient in this category, a suicide risk assessment will be completed by the RN. Patients will be placed immediately on suicide precautions in the ED with possessions removed and the patient placed with a sitter who is in direct line of sight. Beginning on May 21, 2010, on the camera unit, charge nurses conducted one on one education with sitters coming onto the next shift as well as nursing staff regarding the new policies and guidelines surrounding L2K patients and those patients identified to be at risk of self harm Staff were instructed that anyone serving as a sitter or camera monitor are to have no distractions. (Attachment 3) A new unit policy requires monitor	
S 150 SS=D	NAC 449.332 Discharge Planning 8. Activities related to discharge planning must be conducted in a manner that does not contribute to delays in the discharge of the patient. This Regulation is not met as evidenced by: Based on interview, record review and document review, the facility's social worker, case manager	S 150		

Approved 6/17/10 (Approval Expires)

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE W O Wayne TITLE CFO (X6) DATE 6/4/2010

STATE FORM 6899 M1VY11 If continuation sheet 1 of 38

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LAS VEGAS, NEVADA

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S 150	Continued From page 1 and nursing staff failed to prevent a delay and a cancelation of the patients transfer to a psychiatric facility by not notifying the patients physician that a psychiatric evaluation ordered prior to the transfer had been completed. (Patient#1) Severity: 2 Scope: 1	S 150	techs to switch off every two to four hours; A sign is posted at the desk stating that the technician is monitoring pt. safety; please do not disturb. Staff were reminded that if additional information comes to light after the initial assessment that places the patient in this category, a suicide risk assessment will be completed by the RN. Patients who score a 3 or higher will be placed immediately on suicide precautions with possessions removed and the patient placed with a sitter who is in direct line of sight. Rounding on these units began on May 22 by the Patient Safety Officer and/or Charge Nurses to observe practices and provide immediate feedback to the Charge Nurses and/or Directors. Case Managers received training on June 3, on legal holds and checklists were developed to guide their discharge process. Effective May 21, Case Managers and/or Charge Nurses began reading all intake evaluations on psychiatric transfers and authenticating on the document placed in the medical record. Security guards received one on one education beginning May 21 regarding completion of possession logs and policies regarding release of belongings to psychiatric patients who are being transferred or discharged. (Attachment 4)	
S 154 SS=J	NAC 449.332 Discharge Planning 12. If, during the course of a patient's hospitalization, factors arise that may affect the needs of the patient relating to his continuing care or current discharge plan, the needs of the patient must be reassessed and the plan, if any, must be adjusted accordingly. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility's social worker failed to read a comprehensive psychiatric assessment provided by an intake coordinator that indicated the patient was a suicide risk and required low risk suicide precautions. The facility failed to reassess the patients plan of care and provide for protective supervision and the patients safe and timely transfer to a psychiatric facility. (Patient#1) A Physician Order dated 05/19/10 at 9:40 AM documented the following: 1. (Psychiatric Hospital Psych eval). All in-patient psych facility eval. A Case Management Note dated 05/19/10 at 10:29 documented the following: "(Physician#1) wants a psych eval. (Psychiatric Hospital) to evaluate."	S 154	S150 a. There were no other patients that would have been affected. b. Policy AP 12 Suicide Assessment and Precautions (Attachment 5) and CM 06, "Discharge Planning", (Attachment 6) have been revised by the Mental Health Task Force to establish roles and responsibilities of case managers, social workers and designees to facilitate a timely discharge. Policy CM06 states that all patients will be screened by case management on admission. Patients meeting defined triggers will receive a secondary discharge assessment within 24 hours by case management . See CM06 Attachment A – Trigger List	

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S 154	Continued From page 2 A Psychiatric Hospital Comprehensive Assessment Tool dated 05/19/10 at 11:20 AM and completed by an Intake Coordinator documented the following: "(Patient #1) 59 year old Caucasian male reports has been non compliant with medications for past week. Patient during assessment is easily overwhelmed and becomes frustrated stating he can' t think right. Patient ruminative about financial worries for himself, the state of the nation. Mild paranoia and delusional thinking; patient states he incorporates things from the television into real life, reporting that there has been a lot on TV about armageddon and that he sees signs of that in the real world around him. Patient reports daily flashbacks to Vietnam incorporating auditory, visual and olfactory hallucinations. Patient reports inability to sleep past 2-3 days, no appetite and that he has been isolating. Patient reports SI (suicidal ideation) but denies he would act on that. He reports a prior suicide attempt 3 years ago via hanging, "the rope broke." The Comprehensive Assessment Tool documented symptoms and behaviors that were indicative of the need for 24 hour monitoring and assessment of the patient's condition were documented as follows: 1. Hallucinations 2. Acute onset of confusion 3. Inability to sleep The Comprehensive Assessment Tool documented severe deterioration of level of functioning. The patient's medications included the following: 1. Wellbutrin 150 mg every morning.	S 154	c. Ownership and accountability for patient assignments was clarified through staff education (social workers, case managers and nursing) of Policy CM06 and expectations of nursing staff when case management is not available. Revisions to Policy AP12 and CP02 "Legal 2000" (Attachment 7) state that the patient's clinical care will continue until the patient departs the facility. A case management discharge checklist has been revised by the Mental Health Task Force subcommittee on discharge planning. This tool is completed for transfers to psychiatric facilities. The checklist status is part of the handoff between shifts. The policy outlines the process of notification of the healthcare team throughout the discharge planning process and establishes a timeline for escalation up the chain of command for any delay beyond two hours. d. Concurrently, case management will complete the transfer/discharge checklist for 100% of psychiatric transfers/discharges (Attachment 8). In addition, a retrospective audit will be conducted for timeliness of 100% psychiatric transfers/discharges for the next three months following corrective action. The audit will review timeliness of transfer/discharge: assessment, order, paperwork completion, transport requested and patient disposition using the Mental Health Tracking Tool. (Attachment 9) Results will be aggregated, analyzed and reported to the Mental Health Task Force, MEC and the Board of Trustees. e. Chief Nursing Officer Director, Case Management f. Policy AP12 was approved by MEC June 2, 2010 and will be approved by the Board on June 10, 2010. 93% of case management staff completed education on June 3, 2010 on the discharge/transfer process related to the inpatient with a psychiatric diagnosis.	

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S 154	Continued From page 3 2. Celexa 20 mg daily 3. Zyprexa 15 mg at night 4. Trazadone HCL 300 mg at night. 5. Xanax 5 mg when needed 6. Roxicodone 20 mg three times daily. The patient's mental status was described as alert to person, place and time. The patient was anxious, focused, paranoid, with auditory, visual and olfactory hallucinations during flash backs. The patient had no memory impairments and good insight. The patient's suicide risk included the following: 1. History of suicide attempts. 2. Impulsivity 3. Alcohol or heavy drug use Current Risk to self/others documented the following: 1. The patient was having suicidal ideation or making suicidal threats? Answer was yes. 2. Was the ideation repetitive or persistent? Answer was yes. 3. Three years ago the patient attempted to hang himself with a rope. The rope broke. The evaluation of suicide risk was low. The initial treatment focus documented the following: 1. Patient will demonstrate improved reality orientation. Cessation of acute psychotic symptomatology. 2. Initiated or stabilized medication regimen. 3. Patient will demonstrate improved-stabilized mood. The Psychiatric Hospital Comprehensive	S 154	Draft of discharge planning policy (CM 06) was completed June 4, 2010 pending Board approval on June 10, 2010. Training of nursing and case management staff on the process for implementing the chain of command for delays in the discharge/transfer process began on June 4, 2010. Revised Case management discharge checklist was implemented June 4, 2010 S154 a. There were no other patients that would have been affected. b. All inpatients are assessed on admission by nursing and/or case management/social services. Documentation of the assessment is recorded in the electronic health record (EHR) and available for all caregivers to review. Criteria have been developed to trigger a case management/social work referral for patients with a psychiatric diagnoses or who are at risk for self harm. At risk patients triggered by criteria will be reassessed daily by case management/social services. Results of the assessment will be documented in the EHR as well as discussed with the healthcare team. The plan of care will be updated as reassessment occurs with documentation in the EHR. Interdisciplinary Team meetings will continue with appropriate plan of care changes documented. Nursing, case management and social service staff are educated as to assessment and reassessment screens and the mechanism for updating of the plan of care in the EHR. The trigger list was updated to policy CM06, Discharge Planning, on June 4. c. A letter was sent by the CNO on June 4, 2010 to all mental health facilities stating	

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S 154	Continued From page 4 Assessment High Risk Notification Alert Form dated 05/19/10 documented the following. The suicide precautions box was checked. Risk was documented as low. On 05/21/10 at 1:30 PM an interview was conducted with the patients Social Worker. The Social Worker reported the Intake Coordinator from the psychiatric hospital handed her the completed comprehensive assessment on Patient #1. The Social Worker reported due to the fact the patient signed voluntarily to be transferred to the psychiatric hospital and was not on a legal hold she placed the packet in the patients chart and did not read the comprehensive assessment. The Social Worker reported she was not aware the Intake Coordinator documented that the patient was experiencing repetitive and persistent suicidal ideation and recommended a low risk suicide precautions for the patient. The Social Worker acknowledged she did not notify the patient there was a delay in his transfer to the psychiatric facility or the reason for the delay. On 05/21/10 at 2:00 PM an interview was conducted with the patients Case Manager. The Case Manager reported see did not have contact or any conversation with the Intake Coordinator from the psychiatric hospital who conducted the comprehensive assessment on the patient. The Case Manager reported she never read the comprehensive assessment that had been done on the patient was not aware the Intake Coordinator documented that the patient was experiencing repetitive and persistent suicidal ideation and recommended a low risk suicide precautions for the patient. The Case Manager acknowledged she did not notify the patient there was a delay in his transfer to the psychiatric	S 154	that MountainView Hospital will require both a written copy of their assessment as well as a verbal report. (Attachment 10) This report will be provided to the case management staff at the time it is completed. If case management is not available, the report will be provided to the Charge Nurse. The recipient of the report will be required to read it, document acknowledgement that report is read and understood by signing, dating and timing the document; the recipient will report to the physician and caregivers any findings that would result in a change in the plan of care or discharge plan. Changes will be documented in the EHR; a copy of the report will be placed in the patient's medical record. For patients determined to be at risk of self harm or requiring heightened observation, repeat nursing evaluations will be required every two hours. d. 100% of inpatient psychiatric discharge/transfers will be conducted monthly for the next three months. Audit criteria will include evidence that documentation of intake evaluations is present in the medical record, authentication of the report by the case manager, social worker or charge nurse if the plan of care was modified as required by the findings and if the physician was notified as appropriate. Results will be aggregated, analyzed and reported to the Mental Health Task Force, MEC and Board of Trustees. e. Chief Nursing Officer is responsible for notification of outside agencies and psychiatric facilities. Director, Case Management is responsible for assuring process for handoff communication with outside agency staff Director, Case Management will work with EHR programmers to activate social work referral screens in the EHR.	

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S 154	Continued From page 5 facility or the reason for the delay. The Case Manager reported that comprehensive assessments were only reviewed if the patient was on a legal hold or at risk. The Case Manager reported after the comprehensive assessment was completed she called Physician#1 and advised him the patient had voluntarily signed himself into the psychiatric facility. Physician #1 advised he would be in personally to complete the transfer summary but never showed up. After reviewing the patient's comprehensive assessment the Case Manager stated, "This is one that should have been on a legal hold." The Case Manager acknowledged that the documentation in the assessment indicated the patient was having suicidal ideation that was repetitive and should have been on suicide precautions. A Case Manager Note dated 05/19/10 at 1:18 PM indicated Patient #1 signed himself voluntarily into a (psychiatric hospital). "Called and advised (Physician #1), he will return to do discharge summary." A Social Workers Note dated 05/19/10 at 5:58 PM indicated Physician #1 had not been in yet. The patients Social Worker gave report to the Charge R.N. "She will pass on to night charge that patient is accepted at the psychiatric hospital. Once (Physician #1) does the transfer summary, certificate of transfer, and order need to be added to the chart copy. Social Worker instructed Charge R.N. to call medicar for transport." On 05/21/10 at 2:00 PM a telephonic interview was conducted with the Intake Coordinator. The	S 154	Director of Med/Surg and Director of Emergency Services are responsible for staff education regarding the need for ongoing assessment/reassessment and modifications to plan of care f. Letter to outside agencies was sent June 4, 2010 Review of outside agency reports by case management was implemented effective June 1, 2010 EHR social work automatic referral screens will be implemented by July 19, 2010 Education was conducted with case management/ social services on May 24, 2010.	

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S 154	Continued From page 6 Intake coordinator reported after completion of the psychiatric assessment on Patient #1 the report was handed to the patients social worker. The Intake Coordinator reported the social worker was to follow up with the patients physician and arrange transportation to the psychiatric hospital. The Intake Coordinator reported she was told the patient would be transferred within a few hours. The intake Coordinator reported she assumed the social worker would read the assessment and report the findings to the physician. The Intake Coordinator reported due to the patients suicidal ideation and the recommendations made on the psychiatric assessment report for low risk suicide precautions she assumed the facility would monitor the patient closely. On 05/24/10 at 9:00 AM, a telephonic interview was conducted with Physician #1. Physician #1 reported he was called by the Case Manager on 05/19/10 in the early afternoon and advised that the patient had agreed to voluntarily enter the psychiatric hospital for treatment. Physician #1 reported he was never notified by the Case Manager, Social Worker or Nursing staff that the the psychiatric evaluation had been completed or the results of the psychiatric evaluation conducted on the patient. Physician #1 reported if he had been provided with the results of the report that indicated the patient was having repetitive and persistent suicidal ideation with a past history of a suicide attempt by hanging he would have placed the patient on suicide precautions. Physician #1 reported it was his expectation that the Intake Coordinator, Social Worker, Case Manager or Nursing staff would have reviewed the report and notified him of its contents.	S 154		

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S 154	Continued From page 7 Severity: 4 Scope: 1 Complaint # 25388	S 154		
S 300 SS=J	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to assess and provide appropriate care and protective supervision to a patient at risk for suicide that had psychiatric, behavioral and alcohol problems and repetitive and persistent suicidal ideation. (Patient #1) A facility Emergency Room Record dated 05/17/10 at 8:08 AM indicated the patient arrived by ambulance with chief complaints that included chest pain, decreased mental status and changed mental status which started several days ago and was still present. The patient had consumed alcohol recently. The patient appeared in distress and was disorientated to place, time and situation. The patients listed diagnoses included chest pain, anxiety disorder, bipolar disorder, post traumatic stress disorder, chronic pain syndrome, alcohol dependence and altered mental status.	S 300	S300 a. There were no other patients that would have been affected. b. On May 21, 2010, an interim process was immediately activated by the Chief Nursing Officer requiring all patients on legal hold and all patients at risk for suicide to have a sitter or be placed under continuous surveillance by line of sight. (See Intro, Attachment 1 and 3) Staff must accompany the patients to the bathroom and check in verbally with the patient every minute. If there is no response, the staff member will visually observe the patient. Patient care staff on units where sitters are being utilized received one on one education with the charge nurse when they came onto the shift effective May 21, 2010. c. A behavioral health consultant was retained on June 1, 2010 to assist in developing a plan of correction appropriate for an acute care facility. On June 1, the consultant toured the ED, camera unit, physical plant, reviewed policies; provided sample documents; and educated the Mental Health Task Force members. As a result, policies and processes were developed, reviewed and/or revised to provide a comprehensive approach to protect our psychiatric population. The following documents were revised or developed on or before June 3, 2010 by the Mental Health Task Force as a result of this consultation. Policies and Related Forms • Discharge planning policy was revised to include escalation practices, updated triggers for a detailed case management assessment, requirement for intake assessment to be left and reviewed by	

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S 300	Continued From page 8 A Physician Consultation report dated 05/17/10 indicated the patient was a 59 year old male with a history of coronary disease. "The patient was a very poor historian and had a history of bipolar disorder and anxiety disorder which can easily be provoked. The patient is admitted here for problems. He has multiple medical issues and also including a psychotic disorder. He is admitted here with a recent episode of chest pain symptoms." An Admission History and Physical dated 05/17/10 indicated the patient was admitted for evaluation and treatment of atypical chest pain. The patient had a history of anxiety disorder and the plan of care included a psychiatric evaluation and Zyprexa medication. An Emergency Room Note dated 05/17/10 at 8:41 AM indicated the patients wife called to notify the facility the patient had not been taking his psychiatric medication and his psychiatrist at a (psychiatric hospital) would like the patient transferred to the psychiatric unit. Physician #2 was notified. Nursing Note dated 05/17/10 at 10:51 AM documented the following. "Spoke with Physician #2 regarding patient transfer. She will contact psychiatric hospital and call back to notify us if they are able to take him. " A Nursing Note dated 05/17/10 at 8:10 PM indicated the patients belonging list was completed and the patient s belongings were placed in a bag and given to hospital security. "Collection of belongings was witnessed by hospital staff."	S 300	• case managemenT/charge nurse (CM 06) • Legal 2000 policy (CP 02) was revised to clarify the flow of processes • Suicide Assessment and Precautions (AP 12) has been revised to include specifics regarding when to complete the assessment, an expansion of suicide precautions, reporting and documentation requirements. • 'Continuous Observation: Camera and Sitter' (CP 117) has been developed to include patient evaluation, monitoring, reporting and documentation requirements. This policy also defines criteria for placing patients in various levels of continuous observation based on exhibited behaviors and the types of behaviors that are required to be reported to the nurse immediately. (Attachment 11) Completed Education • Review of EHR Case management/social work EHR screens • Review of InterQual Behavioral Health criteria for anxiety, depression and psychosis • One to one education of staff in sitter roles related to sitter responsibilities Tools • Related documentation tools have been developed to include: o Suicide Precautions Observation Record, (Attachment 12) o Sitter Observation Record (Attachment 13) o Camera Observation Record; (Attachment 14) • Additional forms: o Mental Health Tracking Tool o Signs for inpatient units: Continuous Observation (Attachment 15) and Suicide Precautions (Attachment 16) o Competency statement for Patient Observation, and Recognition (Attachment 17) /Reporting of "Unsafe"	

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S 300	Continued From page 9 On 05/21/10 at 10:30 AM the facility Vice president of Quality and Risk Management provided a copy of the most current facility policy for Self Harm Risk Assessment/Suicide Precautions that the facility was following. The Vice President of Quality and Risk Management confirmed the facility nurses were following the above listed policy and procedure for self harm and risk assessment. The facility's Self Harm Risk Assessment/Suicide Precautions Policy and Procedure included the following: Scope: "All Inpatient Nursing Departments" Purpose: A. "To provide guidelines for Registered Nurse (R.N.) performing suicide assessment." B. "To identify and provide optimal safety for patients at risk for suicide." Policy: A. Emergency Department: All patients presenting to the emergency department for psychiatric, behavioral, drug or alcohol problems, or with a history of the same, will be assessed for harm/suicide risk by R.N. Documentation will be completed in the T-System harm assessment/suicide screens. 1. All patients with above noted criteria will be placed on suicide precautions. 2. Patients found at risk for suicide will be screened further by a Mental Health Assessor. " B. Inpatients: Inpatients exhibiting psychiatric, behavioral, drug or alcohol problems, or history of the same, will be screened by an R.N. utilizing the self harm risk screening tool in Meditech. "All personal items should be removed from the	S 300	○ Behaviors. (See Appendix I in AP12:Attachment 5 and CP 117 :Attachment 11) ○ Competency for discharge planning under development ○ Tracer tool (Attachment 18) ○ Education for family and visitors as well as a suicide precautions educational poster was also developed by the Task Force on May 28. (Attachment 19) Formal staff education is under development on the above topics including: i. New policies and staff responsibilities for assessment, care and documentation. ii. New forms and staff responsibilities. iii. New processes/monitoring and staff responsibilities. iv. Suicide risk assessment HealthStream course v. Key strategies for case managers for discharge planning vi. How to evaluate a patient's home medications to detect underlying mental health conditions The educational plan requires mandatory review by all nursing staff, case management/social service staff, sitters, camera techs, EVS staff and security of the above documents. Physicians will be advised of their role via medical staff letters, newsletters and committee agenda items. d. Concurrent rounding was implemented on May 22, 2010; Any noted deficiencies are immediately reported to the Charge Nurse and Director for immediate corrective action. Formal tracers began on June 4, 2010 with use of a tracer tool. Results will be aggregated, analyzed and reported to the Mental Health Task Force, MEC and Board of Trustees. e. Chief Nursing Officer VP Quality/Risk Management f. Policies will be approved at the next MEC/Board meeting on June 10, 2010	

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S 300	Continued From page 10 patient. This includes all clothing, colognes, writing instruments, sharps, plastic bags, medications, matches, lighters, and communication equipment. Document items removed and to which secure location they were sent. Belongings will not be returned to patients being transferred to psychiatric facilities, belongings will be given to the transporter at the time of transfer." On 05/21/10 at 10:30 AM, the Chief Nursing Officer provided a second Suicide Risk Policy effective 01/20/08 and last revised 03/13/08. The Chief Nurse indicated the second policy was the policy the nursing staff should follow for suicide risk assessment. The policy included the following: Policy: "All patients presenting to the Emergency department for psychiatric, behavioral, drug or alcohol problems will be assessed for suicide risk." Procedure: "Utilizing the psychiatric complaint template in the T-System, suicidal and homicidal assessment will be completed. If it is determined that suicidal/homicidal tendencies exist, notify the Physician and place the patient on suicide precautions." "A search and recovery of all potentially harmful items should be conducted by an R.N. in the presence of Security personnel. All clothing should be removed. All sharps, including glass objects, razors, scissors, nail files, etc will be removed. Belts, scarves, matches and plastic bags should be sent home with the family or removed from the patient's room. All medications will be removed from the patient's room and sent to the pharmacy. Cell phones, I	S 300	Policies drafted per consultant feedback were completed on June 4, 2010 with education to staff on an immediate one on one basis Forms, Tools, Posters have been implemented effective June 4, 2010 Suicide Risk Assessment Course assigned to all hospital staff on June 4, 2010 to be completed by June 30, 2010.	

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S 300	Continued From page 11 pods and electronic/communication equipment will be removed. The results of the search should be documented to include personnel present and all items removed. All items will be placed in the custody of security." "An RN/LPN will check the patient as his/her condition indicates, but no less than once every hour. Assessment of the intensity level of suicidal ideation will be charted each shift. The RN/LPN will notify the physician/psychiatrist of major changes in ideation." On 05/21/10 at 11:00 AM a review Patient #1s medical record revealed no documented evidence that a self harm risk assessment for suicide precautions was completed by emergency room nursing staff and documented in the medical record. On 05/21/10 at 12:00 PM an interview was conducted with the Director of Emergency Services. The Director confirmed the emergency room nursing staff failed follow the facility's Self Harm Risk Assessment/Suicide Precautions policy and procedure. The Director confirmed the emergency room nursing staff failed to assess Patient #1 for suicide risk and failed to document any psychiatric assessments in the T-System Harm Assessment/Suicide Screen. On 05//21/10 at 10:30 AM, the Chief Nursing Officer reported due to the patient being a fall risk and having psychiatric diagnoses the patient was transferred to the fourth floor and placed in a camera room for 24 hour observation with another patient. Patient #1 was not placed suicide watch. The patients clothing had been taken and secured by security. A monitor technician was assigned to continuously observe	S 300		

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S 300	Continued From page 12 2 monitors that visualized 10 rooms and 12 patients. Some of the patients were on suicide watch. The camera could not visualize patients who entered the bathroom area. The Chief Nursing Officer reported there was no written facility policy or procedure that specified how many minutes could elapse when a patient entered the bathroom out of the visual field of the camera prior to notifying a staff member to check on the patient. The Chief Nursing Officer indicated the camera technicians should notify nursing staff to check on an at risk or suicide watch patients safety within 3 minutes of them entering a bathroom out of the cameras visual field. The patient's physician ordered for a psychiatric evaluation to be completed on the patient. On 05/19/10 an Intake Coordinator from a psychiatric hospital responded and completed a comprehensive psychiatric assessment on the patient. The Intake Coordinator handed the assessment to the patients Social Worker who placed the packet in the patients chart. The discharge plan included transferring the patient to a psychiatric hospital for psychiatric care. The Chief Nurse acknowledged the Social Worker did not read the Intake Coordinators psychiatric assessment of the patient. The Chief Nursing Officer reported on 05/19/10 at approximately 4:30 PM facility security was called to bring the patients clothing up to the th floor nursing unit in preparation for the patients transfer. The Chief Nurse reported somehow the patient got access to his clothing and changed out of his gown and put his clothing on. The Chief Nursing Officer reported th floor staff on duty that night was questioned and no staff member acknowledged giving the patients his clothing.	S 300		

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S 300	Continued From page 13 The Chief Nurse acknowledged Patient #1 was seen by his nurse at 8:00 PM lying in bed with street clothing on. The Chief Nursing officer acknowledged according to facility policy patients being transferred to a psychiatric facility should not have been given access to their street clothes and should have remained in a hospital gown while a patient at the hospital and during transport to a receiving facility. At 11:00 PM the patient was seen by the camera tech getting out of bed and walking into the bathroom. The door was left partially open. At 11:10 PM a CNA entered the patient's room to take vital signs on Patient #2. Patient #2 asked the CNA to check on Patient #1. The CNA then entered the bathroom and found Patient #1 hanging from the shower rod by a belt around his neck. The patients nurse was notified by the CNA and responded and cut the belt from around the patient's neck and started CPR. (cardiopulmonary resuscitation) The Chief Nursing Officer reported there was a 10 minute window from the time the camera tech saw the patient enter the bathroom to the time the CNA discovered the patient hanging from a belt in the shower. A Nursing care Plan for Patient #1 initiated 05/17/10 included the following: The patients admit was related to an emotional or behavioral disorder. The patient's status was described as confused at times and afraid. The patient had a history of psychiatric care, excessive alcohol or drug abuse and a loss of rational thinking. Problems listed on the patients nursing care plan included the following: Suicide Risk/Ideation:	S 300		

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S 300	Continued From page 14 Patient has risk for suicide. Patient will be free from suicidal ideation. A Physician Order dated 05/19/10 at 9:40 AM documented the following: 1. (Psychiatric Hospital Psych eval). All in-patient psych facility eval. A Case Management Note dated 05/19/10 at 10:29 documented the following. "(Physician#1) wants a psych eval. (Psychiatric Hospital) to evaluate." A Psychiatric Hospital Comprehensive Assessment Tool dated 05/19/10 at 11:20 AM and completed by an Intake Coordinator documented the following: "(Patient #1) 59 year old Caucasian male reports has been non compliant with medications for past week. Patient during assessment is easily overwhelmed and becomes frustrated stating he can' t think right. Patient ruminative about financial worries for himself, the state of the nation. Mild paranoia and delusional thinking; patient states he incorporates things from the television into real life, reporting that there has been a lot on TV about Armageddon and that he sees signs of that in the real world around him. Patient reports daily flashbacks to Vietnam incorporating auditory, visual and olfactory hallucinations. Patient reports inability to sleep past 2-3 days, no appetite and that he has been isolating. Patient reports SI (suicidal ideation) but denies he would act on that. He reports a prior suicide attempt 3 years ago via hanging, "the rope broke." The Comprehensive Assessment Tool documented symptoms and behaviors that were indicative of the need for 24 hour monitoring and assessment of the patient's condition were	S 300		

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S 300	Continued From page 15 documented as follows: 1. Hallucinations 2. Acute onset of confusion 3. Inability to sleep The Comprehensive Assessment Tool documented severe deterioration of level of functioning. The patient's medications included the following: 1. Wellbutrin 150 mg every morning. 2. Celexa 20 mg daily 3. Zyprexa 15 mg at night 4. Trazadone HCL 300 mg at night. 5. Xanax 5 mg when needed 6. Roxicodone 20 mg three times daily. The patient's mental status was described as alert to person, place and time. The patient was anxious, focused, paranoid, with auditory, visual and olfactory hallucinations during flash backs. The patient had no memory impairments and good insight. The patient's suicide risk included the following: 1. History of suicide attempts. 2. Impulsivity 3. Alcohol or heavy drug use Current Risk to self/others documented the following: 1. The patient was having suicidal ideation or making suicidal threats? Answer was yes. 2. Was the ideation repetitive or persistent? Answer was yes. 3. " Three years ago the patient attempted to	S 300		

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S 300	Continued From page 16 hang himself with a rope. The rope broke. " The evaluation of suicide risk was low. The initial treatment focus documented the following: 1. Patient will demonstrate improved reality orientation. Cessation of acute psychotic symptomatology. 2. Initiated or stabilized medication regimen. 3. Patient will demonstrate improved-stabilized mood. The Psychiatric Hospital Comprehensive Assessment High Risk Notification Alert Form dated 05/19/10 documented the following. The suicide precautions box was checked. Risk was documented as low. On 05/21/10 at 1:30 PM an interview was conducted with the patients Social Worker. The Social Worker reported the Intake Coordinator from the psychiatric hospital handed her the completed comprehensive assessment on Patient #1. The Social Worker reported due to the fact the patient signed voluntarily to be transferred to the psychiatric hospital and was not on a legal hold she placed the packet in the patients chart and did not read the comprehensive assessment. The Social Worker reported she was not aware the Intake Coordinator documented that the patient was experiencing repetitive and persistent suicidal ideation and recommended a low risk suicide precautions for the patient. The Social Worker acknowledged she did not notify the patient there was a delay in his transfer to the psychiatric facility or the reason for the delay. On 05/21/10 at 2:00 PM an interview was conducted with the patients Case Manager. The	S 300		

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S 300	Continued From page 17 Case Manager reported see did not have contact or any conversation with the Intake Coordinator from the psychiatric hospital who conducted the comprehensive assessment on the patient. The Case Manager reported she never read the comprehensive assessment that had been done on the patient was not aware the Intake Coordinator documented that the patient was experiencing repetitive and persistent suicidal ideation and recommended a low risk suicide precautions for the patient. The Case Manager acknowledged she did not notify the patient there was a delay in his transfer to the psychiatric facility or the reason for the delay. The Case Manager reported that comprehensive assessments were only reviewed if the patient was on a legal hold or at risk. The Case Manager reported after the comprehensive assessment was completed she called Physician#1 and advised him the patient had voluntarily signed himself into the psychiatric facility. Physician #1 advised he would be in personally to complete the transfer summary but never showed up. After reviewing the patient's comprehensive assessment the Case Manager stated, "This is one that should have been on a legal hold." The Case Manager acknowledged that the documentation in the assessment indicated the patient was having suicidal ideation that was repetitive and should have been on suicide precautions. A Case Manager Note dated 05/19/10 at 1:18 PM indicated Patient #1 signed himself voluntarily into a (psychiatric hospital). "Called and advised (Physician #1), he will return to do discharge summary."	S 300		

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S 300	Continued From page 18 A Social Workers Note dated 05/19/10 at 5:58 PM indicated Physician #1 had not been in yet. The patients Social Worker gave report to the Charge R.N. "She will pass on to night charge that patient is accepted at the psychiatric hospital. Once (Physician #1) does the transfer summary, certificate of transfer, and order need to be added to the chart copy. Social Worker instructed Charge R.N. to call medicar for transport." On 05/24/10 at 9:00 AM, a telephonic interview was conducted with Physician #1. Physician #1 reported he was called by the Case Manager on 05/19/10 in the early afternoon and advised that the patient had agreed to voluntarily enter the psychiatric hospital for treatment. Physician #1 reported he was never notified by the Case Manager, Social Worker or Nursing staff that the the physicist evaluation had been completed or the results of the psychiatric evaluation conducted on the patient. Physician #1 reported if he had been provided with the results of the report that indicated the patient was having repetitive and persistent suicidal ideation with a past history of a suicide attempt by hanging he would have placed the patient on suicide precautions. Physician #1 reported it was his expectation that the Intake Coordinator, Social Worker, Case Manager or Nursing staff would have reviewed the report and notified him of its contents. On 05/21/10 at 2:00 Pm a telephonic interview was conducted with the Intake Coordinator. The Intake coordinator reported after completion of the psychatric assessment on Patient #1 the report was handed to the patients social worker. The Intake Coordinator reported the social worker was to follow up with the patients	S 300		

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S 300	Continued From page 19 physician and arrange transportation to the psychiatric hospital. The Intake Coordinator reported she was told the patient would be transferred within a few hours. The intake Coordinator reported she assumed the social worker would read the assessment and report the findings to the physician. The Intake Coordinator reported due to the patients suicidal indeation and the recommendations made on the psychiatric assessment report for low risk suicide precausions she assumed the facility would monitor the patient closely. On 05/21/10 at 9:50 AM an interview was conducted with CNA Camera Technician #1 on the fourth floor. Camera Technician #1 reported she has been working as a camera technician for 4 years and was never given any written facility policy or procedure regarding the operation or monitoring of patients on camera beds. Camera Technician #1 reported based on her assessment of the patients being monitored and the report given on the patient's diagnosis, no more than 5 minutes should elapse before a staff member should be notified to physically check on a patient at risk or on suicide precautions that has entered the bathroom or left the visible field of the camera. On 05/21/10 at 9:45 AM an interview was conducted with the Director of Medical Surgical floor. The Director reported there should be no more than a 2 to 3 minute time lapse before a staff member should be notified to physically check on a patient at risk or on suicide precautions that has entered the bathroom or left the visible field of the camera. On 05/21/10 the Vice President of Quality and Risk Management reported she could not locate	S 300		

Bureau of Health Care Quality and Compliance

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S 300	Continued From page 20 any written policy or procedure for the operation or monitoring of patients on camera beds. A Facility Security Patient Belongings Log indicated Patient #1s clothing was logged into security on 05/17/10, the date the patient was admitted. The log indicated the patients clothing was returned to staff on the th floor on 05/19/10. On 05/21/10 at 2:30 PM an interview was conducted with Security Guard #1. The Security Guard reported on 05/19/10 at 4:20 PM the nursing staff on 4 north requested Patient #1s belongings be brought up from security. The security Guard reported he brought the patients clothing bag and cane to the 4 th floor at 4:30 PM and provided them to CNA Camera Technician #2. The patients clothing bag and cane were placed in the nursing station on the floor by a printer. Patient #1 was outside his room dressed in a hospital gown at the time and asked if he could have his cane. The Security Guard reported he advised the patient his cane and clothes would be given to the ambulance driver who transported him to the receiving facility. The Security Guard reported the facility policy required all patients transported to another facility were to be transported in a hospital gown. All clothing was to be given to the person transporting the patient at the time of transfer. On 05/21/10 at 3:00 PM an interview was conducted with CNA Camera Technician #2 who confirmed she took possession of the patients clothing bag from security on 05/19/10 at 4:30 PM. Camera Technician #2 reported she was relieved by another camera technician at 5:00 PM and saw that the patients clothing bag was still on the floor in the nursing station by a printer when she left. Camera Technician #2 reported	S 300		

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S 300	Continued From page 21 the facility policy required all patients transported to another facility were to be transported in a hospital gown. All clothing was to be given to the person transporting the patient at the time of transfer. On 05/25/10 at 1:30 PM a telephonic interview was conducted with CNA Camera Technician #3 who reported she was monitoring the cameras the night Patient #1 attempted suicide. The Technician reported at 11:00 PM the patient was seen getting out of bed and walking into the bathroom. The bathroom door was partially ajar but she could not visualize the interior of the bathroom. At 11:10 the camera technician observed a CNA enter the patients room and take vital signs on Patient #2. The Technician reported she observed the CNA enter the bathroom and quickly exit and inform staff the patient had hung himself. The Technician advised since the aptient was not on a legal hold it could be up to 10 minutes before at staff member would check on a patient who entered the bathroom out of the cameras view. Technician #3 reported the facility did not have a written policy or procedure on camera observation duties and responsibilities. Nursing Documentation for 05/19/10 from the patients nurse, RN #1 included the following; 1. 8:00 PM: " Spoke with patient about transfer. He was resting comfortably in street clothes in bed. 2. 9:00 PM: " Rounded, patient medication given. 3. 10:45 PM: " Discovered transfer summary was never completed. Decided patient would have to stay another night. " 4. !0:55 PM: " Called Spring Mountain,	S 300		

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S 300	Continued From page 22 informed them patient would not be transported. " 5. 11:00 PM: " Walked to patient room. Noticed him lying in bed. Looked like patient was sleeping. " 6. 11:10 PM: " CNA came down hall and informed she found patient hanging by his neck in bathroom. I ran to room. Found patient hanging by his belt. Cut belt. Lowered patient to the ground. Called code. Patient did not appear to give any warning intentions leading up to this event. " An Emergency Physician Record dated 05/19/10 at 11:15 PM, indicated the patient hung himself. The patient was last seen at 11:00 PM on his way to a (psychiatric facility). A Respiratory Therapy note dated 05/19/10 at 11:58 PM documented the following: " Patient code 99 on fourth floor. Brought down to ICU. Setting were set by ER doctor. Breath sounds are diminished bilaterally. A Clinical Note dated 05/20/10 indicated Patient #1 had a suicide attempt and was found hanging in his bathroom unresponsive with asystole. The patient was transferred to the ICU. A Nursing Progress Note dated 05/20/10 at 8:26 AM indicated the Patient #1 had a cessation of life signs. The EKG showed flat line. The patient had no pulse or blood pressure. The patient was pronounced dead by R.N. designee. On 05/24/10 at 10:30 Am a telephonic interview was conducted with RN #1. RN #1 reported he was assigned to care for patient #1 on 05/19/10 during the 7:00 PM to 7:00 AM shift on the 4th floor. RN #1 reported when he arrived at 7:00	S 300		

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S 300	Continued From page 23 PM he noticed the patient was dressed in street clothes. RN #1 acknowledged he was aware the patient was being transferred to a psychiatric hospital during his shift but thought only patients on a legal hold were prohibited from wearing street clothing. RN #2 reported the patient did not receive any visitors during the shift. RN #1 reported the patients planned transfer was delayed because the physician had not completed the transfer summary. At 8:00 PM the patient inquired about the delay in his transfer. At 8:00 PM the psychiatric hospital called to inquire as to why the patient had not been transferred. RN #1 reported he found a note in the patients chart that indicated Physician #1 needed to complete the patients transfer summary. RN #1 acknowledged he did not call Physician #1 to inquire about the completion of the patients transfer summary. RN #1 indicated he met with the charge nurse at 11:00 PM and a decision was made to cancel the patients transfer. RN #1 called the psychiatric hospital and informed them the transfer was canceled. RN #1 informed the patient the transfer was canceled at 11:00 PM. RN #1 reported he left the patients room to obtain equipment to place the patient back on cardiac telemetry. At 11:10 PM a CNA came down hall and informed she found patient hanging by his neck in bathroom. He responded to the patients bathroom and found the patient hanging by his belt from a shower curtain rod. He cut the belt and lowered the patient to the ground and called a code. The patient did not appear to give any warning of suicidal intentions leading up to the event. On 05/21/10 at 9:55 AM an interview was conducted with Patient #2 who was the	S 300		

Bureau of Health Care Quality and Compliance

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S 300	Continued From page 24 roommate of Patient #1. Patient #2 reported Patient #1 was in a heavy state of depression over the recent loss of his job as a heavy equipment operator and a divorce from his wife. Patient #2 reported Patient #1 spoke about being transferred to another facility for psychiatric help dealing with his depression. Patient #1s mood went from being depressed to feeling as if things were starting to look up for him due to the help he was going to have dealing with his depression and he was looking forward to his transfer to a mental health facility. Patient #2 reported Patient #1 became increasingly more anxious, agitated and depressed as the evening progressed due to the delay in his transfer. Patient #2 reported he tried to offer assurance to Patient #1 that he would be transferred and that sometimes there can be delays in completing paper work for the transfer. Patient #2 reported on 05/19/10 at approximately 8:00 PM he saw Patient #1 change out of his gown and put on jeans and a shirt. Patient #2 reported he did not see who brought Patient #1s clothing in to him. Patient #1 was watching television and eating. Patient #2 reported he fell asleep around 10:30 PM. At around 12:00 PM a nurse entered the room to take his vital signs and he asked if the nurse to check on Patient #1 who was in the bathroom. Patient #2 then said he heard a lot of commotion and nursing staff running into the room and though they were performing CPR on Patient #1. Patient #2 reported he was then moved to another room. Patient #2 indicated he later learned Patient #1 had attempted to hang himself in the shower. Severity: 4 Scope: 1 Complaint # 25388	S 300		

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S 310	Continued From page 25	S 310		
S 310 SS=J	NAC 449.3624 Assessment of Patient 1. To provide a patient with the appropriate care at the time that the care is needed, the needs of the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Based on observation, interview, record review and document review, the facility staff failed to continually assess the needs of the patient and provide appropriate care and protective supervision to a patient at risk for suicide that had psychiatric, behavioral and alcohol problems and repetitive and persistent suicidal ideation. (Patient #1) A facility Emergency Room Record dated 05/17/10 at 8:08 AM indicated the patient arrived by ambulance with chief complaints that included chest pain, decreased mental status and changed mental status which started several days ago and was still present. The patient had consumed alcohol recently. The patient appeared in distress and was disorientated to place, time and situation. The patients listed diagnoses included chest pain, anxiety disorder, bipolar disorder, post traumatic stress disorder, chronic pain syndrome, alcohol dependence and altered mental status. A Physician Consultation report dated 05/17/10 indicated the patient was a 59 year old male with a history of coronary disease. "The patient was a very poor historian and had a history of bipolar	S 310	S310 a. There were no other patients that would have been affected. b. The ED Self Harm Suicide Risk Assessment policy (See Intro: Attachment 2) was revised, renamed and expanded for housewide use and was approved by the MEC on June 2, 2010 and will be approved by the Board on June 10, 2010. All patients presenting for psychiatric, behavioral, drug or alcohol problems or with history of same, including psychiatric drug use will be assessed for harm/suicide risk by a registered nurse. A request for case management consultation is made for those patients placed on suicide precautions. c. All RN staff have been assigned mandatory education on suicide risk assessment as well as verbal and non verbal cues in identifying the suicidal patient. A request to the Las Vegas IT Governance Board was made on May 24, 2010 to modify the EHR suicide assessment tools and interventions. On June 3, 2010 information regarding disposition of patient's possessions was added to policies CP 117 and AP 12 to include both patients on a legal hold and at risk patients not on legal hold. d. An audit will be conducted for evidence of suicide risk assessment of all patients on legal hold or presenting with psychiatric, alcohol or substance abuse conditions who are transferred or discharged from the ED. Audit for evidence of suicide risk assessment on the same population will be conducted for patients admitted to the hospital or in observation. Audit will be conducted for three months and include 100% of patients with these presenting conditions. Results will be aggregated, analyzed and	

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S 310	Continued From page 26 disorder and anxiety disorder which can easily be provoked. The patient is admitted here for problems. He has multiple medical issues and also including a psychotic disorder. He is admitted here with a recent episode of chest pain symptoms." An Admission History and Physical dated 05/17/10 indicated the patient was admitted for evaluation and treatment of atypical chest pain. The patient had a history of anxiety disorder and the plan of care included a psychiatric evaluation and Zyprexa medication. An Emergency Room Note dated 05/17/10 at 8:41 AM indicated the patients wife called to notify the facility the patient had not been taking his psychiatric medication and his psychiatrist at a (psychiatric hospital) would like the patient transferred to the psychiatric unit. Physician #2 was notified. Nursing Note dated 05/17/10 at 10:51 AM documented the following. "Spoke with Physician #2 regarding patient transfer. She will contact psychiatric hospital and call back to notify us if they are able to take him." A Nursing Note dated 05/17/10 at 8:10 PM indicated the patients belonging list was completed and the patient s belongings were placed in a bag and given to hospital security. "Collection of belongings was witnessed by hospital staff." On 05/21/10 at 10:30 AM the facility Vice president of Quality and Risk Management provided a copy of the most current facility policy for Self Harm Risk Assessment/Suicide Precautions that the facility was following. The	S 310	reported to the Mental Health Task Force, MEC and Board of Trustees. e. Chief Nursing Officer Director, Emergency Services Director, Case Management f. Staff education on the necessity of completing suicide risk assessment in the ED was completed on May 25, 2010. Continuous education will occur as new staff are assigned; The ED policy on handling at risk patients' possessions was expanded to housewide use on June 3, 2010.	

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S 310	Continued From page 27 Vice President of Quality and Risk Management confirmed the facility nurses were following the above listed policy and procedure for self harm and risk assessment. The facility's Self Harm Risk Assessment/Suicide Precautions Policy and Procedure included the following: Scope: "All Inpatient Nursing Departments" Purpose: A. "To provide guidelines for Registered Nurse (R.N.) performing suicide assessment." B. "To identify and provide optimal safety for patients at risk for suicide." Policy: A. Emergency Department: "All patients presenting to the emergency department for psychiatric, behavioral, drug or alcohol problems, or with a history of the same, will be assessed for harm/suicide risk by R.N. Documentation will be completed in the T-System harm assessment/suicide screens. " 1. " All patients with above noted criteria will be placed on suicide precautions." 2. " Patients found at risk for suicide will be screened further by a Mental Health Assessor. " B. Inpatients: "Inpatients exhibiting psychiatric, behavioral, drug or alcohol problems, or history of the same, will be screened by an R.N. utilizing the self harm risk screening tool in Meditech. " "All personal items should be removed from the patient. This includes all clothing, colognes, writing instruments, sharps, plastic bags, medications, matches, lighters, and communication equipment. Document items removed and to which secure location they were	S 310		

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S 310	Continued From page 28 sent. Belongings will not be returned to patients being transferred to psychiatric facilities, belongings will be given to the transporter at the time of transfer." On 05/21/10 at 10:30 AM, the Chief Nursing Officer provided a second Suicide Risk Policy effective 01/20/08 and last revised 03/13/08. The Chief Nurse indicated the second policy was the policy the nursing staff should follow for suicide risk assessment. The policy included the following: Policy: "All patients presenting to the Emergency department for psychiatric, behavioral, drug or alcohol problems will be assessed for suicide risk." Procedure: " Utilizing the psychiatric complaint template in the T-System, suicidal and homicidal assessment will be completed. If it is determined that suicidal/homicidal tendencies exist, notify the Physician and place the patient on suicide precautions." "A search and recovery of all potentially harmful items should be conducted by an R.N. in the presence of Security personnel. All clothing should be removed. All sharps, including glass objects, razors, scissors, nail files, etc will be removed. Belts, scarves, matches and plastic bags should be sent home with the family or removed from the patient's room. All medications will be removed from the patient's room and sent to the pharmacy. Cell phones, I pods and electronic/communication equipment will be removed. The results of the search should be documented to include personnel present and all items removed. All items will be placed in the custody of security."	S 310		

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S 310	Continued From page 29 " An RN/LPN will check the patient as his/her condition indicates, but no less than once every hour. Assessment of the intensity level of suicidal ideation will be charted each shift. The RN/LPN will notify the physician/psychiatrist of major changes in ideation." On 05/21/10 at 11:00 AM a review Patient #1s medical record revealed no documented evidence that a self harm risk assessment for suicide precautions was completed by emergency room nursing staff and documented in the medical record . On 05/21/10 at 12:00 PM an interview was conducted with the Director of Emergency Services. The Director confirmed the emergency room nursing staff failed follow the facility's Self Harm Risk Assessment/Suicide Precautions policy and procedure. The Director confirmed the emergency room nursing staff failed to assess Patient #1 for suicide risk and failed to document any psychiatric assessments in the T-System Harm Assessment/Suicide Screen. On 05//21/10 at 10:30 AM, the Chief Nursing Officer reported due to the patient being a fall risk and having psychiatric diagnoses the patient was transferred to the fourth floor and placed in a camera room for 24 hour observation with another patient. Patient #1 was not placed suicide watch. The patients clothing had been taken and secured by security. A monitor technician was assigned to continuously observe 2 monitors that visualized 10 rooms and 12 patients. Some of the patients were on suicide watch. The camera could not visualize patients who entered the bathroom area.	S 310		

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S 310	Continued From page 30 The Chief Nursing Officer reported there was no written facility policy or procedure that specified how many minutes could elapse when a patient entered the bathroom out of the visual field of the camera prior to notifying a staff member to check on the patient. The Chief Nursing Officer indicated the camera technicians should notify nursing staff to check on an at risk or suicide watch patients safety within 3 minutes of them entering a bathroom out of the cameras visual field. The patient's physician ordered for a psychiatric evaluation to be completed on the patient. On 05/19/10 an Intake Coordinator from a psychiatric hospital responded and completed a comprehensive psychiatric assessment on the patient. The Intake Coordinator handed the assessment to the patients Social Worker who placed the packet in the patients chart. The discharge plan included transferring the patient to a psychiatric hospital for psychiatric care. The Chief Nurse acknowledged the Social Worker did not read the Intake Coordinators psychiatric assessment of the patient. The Chief Nursing Officer reported on 05/19/10 at approximately 4:30 PM facility security was called to bring the patients clothing up to the th floor nursing unit in preparation for the patients transfer. The Chief Nurse reported somehow the patient got access to his clothing and changed out of his gown and put his clothing on. The Chief Nursing Officer reported th floor staff on duty that night was questioned and no staff member acknowledged giving the patients his clothing. The Chief Nurse acknowledged Patient #1 was seen by his nurse at 8:00 PM lying in bed with street clothing on. The Chief Nursing officer acknowledged according to facility policy	S 310		

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S 310	Continued From page 31 patients being transferred to a psychiatric facility should not have been given access to their street clothes and should have remained in a hospital gown while a patient at the hospital and during transport to a receiving facility. At 11:00 PM the patient was seen by the camera tech getting out of bed and walking into the bathroom. The door was left partially open. At 11:10 PM a CNA entered the patient's room to take vital signs on Patient #2. Patient #2 asked the CNA to check on Patient #1. The CNA then entered the bathroom and found Patient #1 hanging from the shower rod by a belt around his neck. The patients nurse was notified by the CNA and responded and cut the belt from around the patient's neck and started CPR. (cardiopulmonary resuscitation) The Chief Nursing Officer reported there was a 10 minute window from the time the camera tech saw the patient enter the bathroom to the time the CNA discovered the patient hanging from a belt in the shower. A Nursing care Plan for Patient #1 initiated 05/17/10 included the following: The patients admit was related to an emotional or behavioral disorder. The patient's status was described as confused at times and afraid. The patient had a history of psychiatric care, excessive alcohol or drug abuse and a loss of rational thinking. Problems listed on the patients nursing care plan included the following: Suicide Risk/Ideation: Patient has risk for suicide. Patient will be free from suicidal ideation. On 05/21/10 at 9:50 AM an interview was conducted with CNA Camera Technician #1 on	S 310		

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S 310	Continued From page 32 the fourth floor. Camera Technician #1 reported she has been working as a camera technician for 4 years and was never given any written facility policy or procedure regarding the operation or monitoring of patients on camera beds. Camera Technician #1 reported based on her assessment of the patients being monitored and the report given on the patient's diagnosis, no more than 5 minutes should elapse before a staff member should be notified to physically check on a patient at risk or on suicide precautions that has entered the bathroom or left the visible field of the camera. On 05/21/10 at 9:45 AM an interview was conducted with the Director of Medical Surgical floor. The Director reported there should be no more than a 2 to 3 minute time lapse before a staff member should be notified to physically check on a patient at risk or on suicide precautions that has entered the bathroom or left the visible field of the camera. On 05/21/10 the Vice President of Quality and Risk Management reported she could not locate any written policy or procedure for the operation or monitoring of patients on camera beds. A Facility Security Patient Belongings Log indicated Patient #1s clothing was logged into security on 05/17/10, the date the patient was admitted. The log indicated the patients clothing was returned to staff on the th floor on 05/19/10. On 05/21/10 at 2:30 PM an interview was conducted with Security Guard #1. The Security Guard reported on 05/19/10 at 4:20 PM the nursing staff on 4 north requested Patient #1s belongings be brought up from security. The security Guard reported he brought the patients	S 310		

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S 310	Continued From page 33 clothing bag and cane to the 4 th floor at 4:30 PM and provided them to CNA Camera Technician #2. The patients clothing bag and cane were placed in the nursing station on the floor by a printer. Patient #1 was outside his room dressed in a hospital gown at the time and asked if he could have his cane. The Security Guard reported he advised the patient his cane and clothes would be given to the ambulance driver who transported him to the receiving facility. The Security Guard reported the facility policy required all patients transported to another facility were to be transported in a hospital gown. All clothing was to be given to the person transporting the patient at the time of transfer. On 05/21/10 at 3:00 PM an interview was conducted with CNA Camera Technician #2 who confirmed she took possession of the patients clothing bag from security on 05/19/10 at 4:30 PM. Camera Technician #2 reported she was relieved by another camera technician at 5:00 PM and saw that the patients clothing bag was still on the floor in the nursing station by a printer when she left. Camera Technician #2 reported the facility policy required all patients transported to another facility were to be transported in a hospital gown. All clothing was to be given to the person transporting the patient at the time of transfer. Nursing Documentation for 05/19/10 from the patients nurse, RN #1 included the following; 1. 8:00 PM: " Spoke with patient about transfer. He was resting comfortably in street clothes in bed. 2. 9:00 PM: " Rounded, patient medication given." 3. 10:45 PM: " Discovered transfer summary	S 310		

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S 310	Continued From page 34 was never completed. Decided patient would have to stay another night. " 4. !0:55 PM: " Called Spring Mountain, informed them patient would not be transported. " 5. 11:00 PM: " Walked to patient room. Noticed him lying in bed. Looked like patient was sleeping. " 6. 11:10 PM: " CNA came down hall and informed she found patient hanging by his neck in bathroom. I ran to room. Found patient hanging by his belt. Cut belt. Lowered patient to the ground. Called code. Patient did not appear to give any warning intentions leading up to this event. " An Emergency Physician Record dated 05/19/10 at 11:15 PM, indicated the patient hung himself. The patient was last seen at 11:00 PM on his way to a (psychiatric facility). A Respiratory Therapy note dated 05/19/10 at 11:58 PM documented the following: " Patient code 99 on fourth floor. Brought down to ICU. Setting were set by ER doctor. Breath sounds are diminished bilaterally. A Clinical Note dated 05/20/10 indicated Patient #1 had a suicide attempt and was found hanging in his bathroom unresponsive with asystole. The patient was transferred to the ICU. A Nursing Progress Note dated 05/20/10 at 8:26 AM indicated the Patient #1 had a cessation of life signs. The EKG showed flat line. The patient had no pulse or blood pressure. The patient was pronounced dead by R.N. designee. On 05/24/10 at 10:30 Am a telephonic interview was conducted with RN #1. RN #1 reported he	S 310		

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S 310	Continued From page 35 was assigned to care for patient #1 on 05/19/10 during the 7:00 PM to 7:00 AM shift on the 4th floor. RN #1 reported when he arrived at 7:00 PM he noticed the patient was dressed in street clothes. RN #1 acknowledged he was aware the patient was being transferred to a psychiatric hospital during his shift but thought only patients on a legal hold were prohibited from wearing street clothing. RN #2 reported the patient did not receive any visitors during the shift. RN #1 reported the patients planned transfer was delayed because the physician had not completed the transfer summary. At 8:00 PM the patient inquired about the delay in his transfer. At 8:00 PM the psychiatric hospital called to inquire as to why the patient had not been transferred. RN #1 reported he found a note in the patients chart that indicated Physician #1 needed to complete the patients transfer summary. RN #1 acknowledged he did not call Physician #1 to inquire about the completion of the patients transfer summary. RN #1 indicated he met with the charge nurse at 11:00 PM and a decision was made to cancel the patients transfer. RN #1 called the psychiatric hospital and informed them the transfer was canceled. RN #1 informed the patient the transfer was canceled at 11:00 PM. RN #1 reported he left the patients room to obtain equipment to place the patient back on cardiac telemetry. At 11:10 PM a CNA came down hall and informed she found patient hanging by his neck in bathroom. He responded to the patients bathroom and found the patient hanging by his belt from a shower curtain rod. He cut the belt and lowered the patient to the ground and called a code. The patient did not appear to give any warning of suicidal intentions leading up to the event.	S 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS640HOS	A. BUILDING _____ B. WING _____	05/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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S 310	Continued From page 36 On 05/21/10 at 9:55 AM an interview was conducted with Patient #2 who was the roommate of Patient #1. Patient #2 reported Patient #1 was in a heavy state of depression over the recent loss of his job as a heavy equipment operator and a divorce from his wife. Patient #2 reported Patient #1 spoke about being transferred to another facility for psychiatric help dealing with his depression. Patient #1s mood went from being depressed to feeling as if things were starting to look up for him due to the help he was going to have dealing with his depression and he was looking forward to his transfer to a mental health facility. Patient #2 reported Patient #1 became increasingly more anxious, agitated and depressed as the evening progressed due to the delay in his transfer. Patient #2 reported he tried to offer assurance to Patient #1 that he would be transferred and that sometimes there can be delays in completing paper work for the transfer. Patient #2 reported on 05/19/10 at approximately 8:00 PM he saw Patient #1 change out of his gown and put on jeans and a shirt. Patient #2 reported he did not see who brought Patient #1s clothing in to him. Patient #1 was watching television and eating. Patient #2 reported he fell asleep around 10:30 PM. At around 12:00 PM a nurse entered the room to take his vital signs and he asked if the nurse to check on Patient #1 who was in the bathroom. Patient #2 then said he heard a lot of commotion and nursing staff running into the room and though they were performing CPR on Patient #1. Patient #2 reported he was then moved to another room. Patient #2 indicated he later learned Patient #1 had attempted to hang himself in the shower.	S 310		

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS640HOS	A. BUILDING _____ B. WING _____	05/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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S 310	Continued From page 37 Severity: 4 Scope: 1 Complaint # 25388	S 310		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.